

Home Care Client Intake Form

Complete with the prospective client or the person arranging care, before agreeing to services.

Agency _____ Date of inquiry _____ Taken by _____

1. Client and Contact Details

Client's full name _____ Date of birth _____ Preferred language _____

Address _____

Phone _____ Email _____

Person arranging care _____ Relationship _____ Phone _____

Emergency contact _____ Relationship _____ Phone _____

Primary doctor _____ Phone _____

2. Health Conditions and Medications

☐ Memory loss or dementia ☐ Mental health condition ☐ Diabetes ☐ Developmental disability ☐ Hospital stay in last 3 months

Diagnoses and conditions, in plain words

Medications (name, dose, how often)

Who manages medications now _____ Allergies _____

Special diet _____

Equipment in use: ☐ Oxygen ☐ Catheter ☐ Feeding tube ☐ Walker or wheelchair ☐ Hospital bed

3. Daily Living Needs

Task	Manages alone	Needs a reminder	Hands-on help	Two people
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Moving from bed to chair	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Taking medications	☐	☐	☐	☐

Household help: ☐ Meals ☐ Laundry ☐ Shopping ☐ Light housekeeping ☐ Rides to appointments

Notes on daily needs _____

4. Home Environment and Safety

Stairs in the home ☐ Yes ☐ No **Bathing:** ☐ Tub ☐ Walk-in shower Smokers ☐ Yes ☐ No Firearms ☐ Yes ☐ No

Pets _____ Who else lives in the home _____

Fall in the past 6 months ☐ Yes ☐ No Details _____

5. Schedule and Service Expectations

Days wanted: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Hours _____ Start date _____

Same caregiver every visit ☐ Yes ☐ No Overnight care ☐ Yes ☐ No Weekends ☐ Yes ☐ No

Other expectations _____

6. Payment and Decision Makers

Who pays: ☐ Client ☐ Family ☐ Long-term care insurance ☐ State program ☐ Other

Power of attorney or guardian ☐ Yes ☐ No Name and phone _____

Who receives updates _____ Who may change the schedule _____

7. Intake Conversation Notes

A good day and a hard day for the client _____

Previous caregivers or agencies, and why it ended _____

How the client feels about receiving help _____

What would make the family call to complain _____

What has changed in the last three months _____

8. Authorized Contacts

People the client allows the agency to speak with about their care.

Name _____	Relationship _____	Phone _____
Name _____	Relationship _____	Phone _____

9. Privacy Acknowledgment

The information on this form is confidential. The agency keeps it in a secure file and shares it only with staff involved in the client's care. By signing, I confirm the information is accurate to the best of my knowledge, and I authorize the agency to discuss the client's care with the contacts listed in section 8.

Signature of client or representative

Printed name

Date